

		FOR OFFICE USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>8000267</u></p> <p>Facility Name: <u>Alton Memorial Hospital Hatch SK N W</u></p> <p>Address: <u>One Memorial Drive</u> <u>Alton</u> <u>62002</u> Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: <u>(618) 463-7301</u> <u>Fax #</u></p> <p>IDPA ID Number: <u>37-0661172</u></p> <p>Date of Initial License for Current Owners: <u>1/1/71</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kenneth J. Wieduwilt</u> Telephone Number: <u>314/653-5317</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Ronald B. McMullen</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>President</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Ronald B. McMullen</u>	Paid Preparer	(Title) <u>President</u>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) <u>()</u> Fax # <u>()</u>																																		

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W# 8000267 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>28</u>	Skilled (SNF)	<u>28</u>	<u>10,248</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>28</u>	TOTALS	<u>28</u>	<u>10,248</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>24</u>	<u>1,706</u>	<u>3,831</u>	<u>5,561</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24</u>	<u>1,706</u>	<u>3,831</u>	<u>5,561</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 54.26%D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐I. On what date did you start providing long term care at this location?
Date started 10/03/86J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 28 and days of care provided 3831Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W # 8000267 Report Period Beginning: 01/01/2000 Ending: 12/31/2000
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
1	A. General Services										
1	Dietary							106,338	106,338		1
2	Food Purchase		3,410		3,410		3,410	0	3,410		2
3	Housekeeping		171		171		171	43,857	44,028		3
4	Laundry							47,035	47,035		4
5	Heat and Other Utilities			4,999	4,999		4,999	150,645	155,644		5
6	Maintenance			1,144	1,144		1,144	109	1,253		6
7	Other (specify):* Cafeteria							0			7
8	TOTAL General Services		3,581	6,143	9,724		9,724	347,984	357,708		8
9	B. Health Care and Programs										
9	Medical Director							0			9
10	Nursing and Medical Records	642,557	33,569		676,126		676,126	76,367	752,493		10
10a	Therapy							0			10a
11	Activities							0			11
12	Social Services							42,801	42,801		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	642,557	33,569		676,126		676,126	119,168	795,294		16
17	C. General Administration										
17	Administrative							136,916	136,916		17
18	Directors Fees							0			18
19	Professional Services			2,700	2,700		2,700	0	2,700		19
20	Dues, Fees, Subscriptions & Promotions							0			20
21	Clerical & General Office Expenses		4,642	6,688	11,330		11,330	19,422	30,752		21
22	Employee Benefits & Payroll Taxes			47,989	47,989		47,989	63,224	111,213		22
23	Inservice Training & Education			675	675		675	0	675		23
24	Travel and Seminar							0			24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice							0			26
27	Other (specify):*							0			27
28	TOTAL General Administration		4,642	58,052	62,694		62,694	219,562	282,256		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	642,557	41,792	64,195	748,544		748,544	686,714	1,435,258		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W # 8000267 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			17,490	17,490		17,490	13,202	30,692			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			999	999		999	0	999			35
36	Other (specify):*											36
37	TOTAL Ownership			18,489	18,489		18,489	13,202	31,691			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							1,090,951	1,090,951			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee							0				42
43	Other (specify):* Cafeteria							50,881	50,881			43
44	TOTAL Special Cost Centers							1,141,832	1,141,832			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	642,557	41,792	82,684	767,033	0	767,033	1,841,748	2,608,781			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number **Alton Memorial Hospital Hatch SK N W** # **8000267** STATE OF ILLINOIS Report Period Beginning: **01/01/2000** Page 5
 VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 Ending: **12/31/2000**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,841,748		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,841,748		36
		(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,841,748		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W

8000267 Report Period Beginning:

01/01/2000

Ending:

Summary A

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary	Operating Expenses												SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I		
1	Dietary	0	106,338	0	0	0	0	0	0	0	0	0	106,338	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	43,857	0	0	0	0	0	0	0	0	0	43,857	3
4	Laundry	0	47,035	0	0	0	0	0	0	0	0	0	47,035	4
5	Heat and Other Utilities	0	150,645	0	0	0	0	0	0	0	0	0	150,645	5
6	Maintenance	0	109	0	0	0	0	0	0	0	0	0	109	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	347,984	0	0	0	0	0	0	0	0	0	347,984	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	76,367	0	0	0	0	0	0	0	0	0	76,367	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	42,801	0	0	0	0	0	0	0	0	0	42,801	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	119,168	0	0	0	0	0	0	0	0	0	119,168	16
C. General Administration														
17	Administrative	0	136,916	0	0	0	0	0	0	0	0	0	136,916	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	19,422	0	0	0	0	0	0	0	0	0	19,422	21
22	Employee Benefits & Payroll Taxes	0	63,224	0	0	0	0	0	0	0	0	0	63,224	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	219,562	0	0	0	0	0	0	0	0	0	219,562	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	686,714	0	0	0	0	0	0	0	0	0	686,714	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W

8000267

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	13,202	0	0	0	0	0	0	0	0	0	13,202	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	13,202	0	0	0	0	0	0	0	0	0	13,202	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	1,090,951	0	0	0	0	0	0	0	0	0	1,090,951	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	50,881	0	0	0	0	0	0	0	0	0	50,881	43
44	TOTAL Special Cost Centers	0	1,141,832	0	0	0	0	0	0	0	0	0	1,141,832	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	1,841,748	0	0	0	0	0	0	0	0	0	1,841,748	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2		There were no payments to related parties.									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Previe

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W# 8000267

Report Period Beginning:

01/01/2000Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2	NOT APPLICABLE												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
 (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
 (See instructions.)

Print Previe

Facility Name & ID Number **Alton Memorial Hospital Hatch SK N W**# **8000267**

Report Period Beginning:

01/01/2000

Ending:

12/31/2000**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	Not Applicable	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,467 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>1,352</u>	1
2					2
3	TOTALS			\$ <u>1,352</u>	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

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Facility Name & ID Number Alton Memorial Hospital Hatch SK N W

8000267

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	SNF Wing Project			1985	2,772					2,772	9
10	New Stairs			1989	8,805	587	15	587		6,751	10
11	Vacuum Cleaning System			1989	868	58	15	58		666	11
12	A/C Project			1989	35,590	1,780	20	1,780		20,462	12
13	Floor Finishes			1996	14,700	1,470	10	1,470		6,125	13
14	Replace Doors in 15 Patient Rooms			1996	10,618	708	15	708		2,950	14
15	Renovate Countertops			1999	7,170	358	20	358		418	15
16	Paint Wall Coverings			1999	1,511	302	5	302		352	16
17	Renovate Tackboards			1999	846	106	8	106		123	17
18	Renovate Door/Frames			1999	1,713	114	15	114		133	18
19	Renovate Vinyl Floor			1999	18,823	1,882	10	1,882		2,196	19
20	Renovate Electrical			1999	13,778	765	18	765		893	20
21	Renovate A/C			1999	2,698	540	5	540		629	21
22	Renovate Drapes			1999	22,658	4,532	5	4,532		5,287	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$ 13,202		\$ 13,202	\$	\$ 49,757	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W# 8000267

Report Period Beginning:

01/01/2000

Ending:

12/31/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 202,997	\$ 17,347	\$ 17,347	\$		\$ 79,867	37
38	Current Year Purchases	0	0	0			0	38
39	Fully Depreciated Assets	30,654	143	143			30,654	39
40								40
41	TOTALS	\$ 233,651	\$ 17,490	\$ 17,490	\$		\$ 110,521	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 30,692	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 30,692	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 160,278	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W

#

8000267

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES
☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐HOURS PER AIDE 3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

Print Preview

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts		NOT APPLICABLE					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
										10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Previe

XV. BALANCE SHEET - Unrestricted Operating Fund.

8000267

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

As of 12/31/2000

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 135,487	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		9,875,259	3
4	Supply Inventory (priced at Cost)		317,459	4
5	Short-Term Investments			5
6	Prepaid Insurance		103,005	6
7	Other Prepaid Expenses		21,214	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Misc Receivables		1,110,525	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 11,562,949	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		525,000	12
13	Land		449,689	13
14	Buildings, at Historical Cost		56,929,252	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		25,421,408	16
17	Accumulated Depreciation (book methods)		(50,816,517)	17
18	Deferred Charges		3,204,130	18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		29,466,515	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 65,179,477	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 76,742,426	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 1,202,462	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		1,175,000	29
30	Accrued Salaries Payable		3,680,567	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities		(2,230,556)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 3,827,473	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		23,685,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other Long-Term Liabilities		4,220,812	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 27,905,812	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 31,733,285	46
47	TOTAL EQUITY (page 18, line 24)	\$ 45,009,141	\$ 45,009,141	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 45,009,141	\$ 76,742,426	48

*(See instructions.)

Print Preview

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 46,281,572	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 46,281,572	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,029,527	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) AMH Net Income Other Than SNF	1,408,903	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,438,430	17
	B. Transfers (Itemize):		
18	Net Assets	(4,710,861)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4,710,861)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 45,009,141	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Alton Memorial Hospital Hatch SK N W

8000267

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,378,863	1
2	Discounts and Allowances for all Levels	(2,582,303)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,796,560	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,796,560	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 9,724	31
32	Health Care	676,126	32
33	General Administration	62,694	33
B. Capital Expense			
34	Ownership	18,489	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 767,033	40
41	Income before Income Taxes (line 30 minus line 40)**	2,029,527	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,029,527	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Preview

Facility Name & ID Number Alton Memorial Hospital Hatch SK N W

8000267

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,715	2,307	\$ 51,467	\$ 22.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,062	13,538	277,049	20.46	3
4	Licensed Practical Nurses	8,946	10,303	125,491	12.18	4
5	Nurse Aides & Orderlies	17,787	20,666	188,550	9.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	40,510	46,814	\$ 642,557 *	\$ 13.73	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	<u>47,989</u>	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance				
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>47,989</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
C. Green, M.D.	MD fees		\$ <u>2,700</u>			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ <u>2,700</u>	TOTAL		\$	TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		Not Applicable											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,672 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. No
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 0
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. ~~Does the facility transport residents to and from day training?~~ No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. audit part of BJC Health Care
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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